STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155304	A. BUILDING 00 B. WING	04/05/2011

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WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN47362

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F0000	This visit was for the Investigation of Complaint IN00088486. Complaint IN00088486- Substantiated, federal/state deficiency related to the allegation cited at F329. Survey dates: April 4, and 5th, 2011 Facility number: 000201 Provider number: 155304 AIM number: 100267910 Survey team: Barbara Gray, RN Census bed type: SNF: 10 SNF/NF: 49 Total: 59 Census payor type: Medicare: 16 Medicaid: 23 Other: 20 Total: 59 Sample: 3 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on April 8, 2011 by Bev Faulkner, RN			
F0329	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
SS=D	Based on interview and record review, the facility failed to thoroughly assess and evaluate a resident with a change in behavior, with no prior history of behavior or psychosis, before placing the resident on an antipsychotic medication (Risperdal), for 1 of 3 residents sampled for medications. (Resident #A) Findings include: Resident #A's record was reviewed on	F0329	F329Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.It is the intent of this facility to thoroughly assess and evaluate a resident with a	04/18/2011

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	4/4/11 at 10:30 A.M. Diagnoses included but were not limited to insulin dependent diabetes, hypertension, difficulty walking, muscle weakness, post below the knee amputee, and renal failure. Resident #A's quarterly Minimum Data Set assessment, dated 11/1/10, indicated resident #A had no behaviors, took no antipsychotic medications, required extensive assistance of one person to transfer, required limited assistance of one person to ambulate, dress, and toilet. A physician's recapitulation order for April, 2011 indicated the following order for Resident #A: Initiated 9/16/10 - tramadol hydrochloride 50 milligram (mg) tablet - 4 times a day at 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M., for pain. A Behavior Monitoring Record for Resident #A, dated 3/2/11 at 2:30 P.M., indicated the following: Behavior - screamed at others, cursed at others, hitting others, and shoving others. Precipitation factors - unknown. Unsuccessful approaches - reassurance, encourage to sit and rest, remove from source of agitation, and re-approach later. Successful approaches - approach by alternate caregiver. Nurses notes for Resident #A indicated		change in behavior, with no prior history of behavior or psychosis, before placing the resident on an antipsychotic medication. I. Actions Taken for Affected Resident The medication was discontinued for Resident #A while in the hospital.II. Other Affected 100% audit of all residents on an antipsychotic was completed, behavior management program was reviewed by the IDT. No other residents were identified.III. Measures Taken In-service all nursing staff re: Behavior Management and Monitoring Program, use of antipsychotic medications, and appropriate documentation.IV. How Monitored a. Social Services/designee to review Referral/Assessment/Determination forms daily as received. ADM/designee will review these forms in the next morning meeting with the IDT for review/recommendation for initiation of the Behavior Monitoring Record. b. IDT members will meet weekly to review residents who have been placed on a Behavior Monitoring Record and make recommendations for interventions based on data collected. c. SSD/designee will complete a Behavior Monitoring Summary form quarterly for residents who have been placed on a Behavior Monitoring Record and these	

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	the following: 3/2/11 at 4:30 P.M. - Due to increased confusion and tearful episodes, family and staff are concerned. Attempted to obtain a straight catheterization for urinalysis, and the resident did not tolerate it well. The resident began crying, and instructed staff to stop the procedure. The procedure was stopped at that time. Writer and witness attempted to calm the resident and explained procedure again. The resident asked staff to help her out of bed, and staff did. Staff then exited the resident's room. The resident exited the room still upset, and appeared confused. Will notify the physician and family about incident. 3/2/11 at 6:00 - The resident agreed to allow this nurse to obtain a urine specimen. The resident tolerated the procedure well with no complaints. A urine culture for Resident #A, dated 3/2/11 at 6:20 P.M., indicated no growth. An interview with RN #1 on 4/5/11 at 3:30 P.M., indicated the entry on the Behavior Monitoring Record, dated 3/2/11 at 2:30 P.M., and the nurses note on 3/2/11 at 4:30 P.M., were documented by her, and were the same incident. RN #1 indicated she did not normally work with Resident #A, and the only day she gave care to Resident #A was 3/2/11. Resident #A refused to let RN #1		summaries will be reviewed in the weekly QA IDT meeting as completed and quaarterly in the QA meeting with the Medical Director.V. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/18/11.	

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	catheterize her. Resident #A began screaming and cursing. After getting Resident #A out of bed, Resident #A began verbally attacking staff, and was making a shoving motion for staff to leave her bedroom. Resident #A continued to yell and curse in the hallway. Resident #A could not be redirected and RN # 1 had to involve the Director of Nursing. The family was called. Resident #A did not physically make contact with anyone. A Behavior Monitoring Record for Resident #A indicated the following: 3/3/11 at 1:00 P.M. - Behavior - screamed at others, cursed at others, hitting at others, and shoving at others. Precipitating factors - fear, and room change. Unsuccessful approaches - move to a quiet area, walk, reassurance, validation of feelings/support, and hold hand. 3/3/11 at 2:30 P.M. - Behavior - screamed at others. Precipitating factors - fear, and room change. Unsuccessful approaches - reassurance, validation of feelings/support, remove from source of agitation, approach by alternate caregiver. Social Service (SS) notes for resident #A indicated the following: 3/3/11 at no time - Spoke with the Director of Nursing (DoN) at 8:15 A.M., that family was upset. Per DoN, family wanting resident to move to another room. SS spoke with			

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	family and informed them Resident #A would be the one who would have to make the move. Family and resident stating O.K. During room move resident upset. Explained to resident again that she and family O.K.'d room move. Resident voiced if she didn't like the room she would go home. 3/3/11 (no time documented) - Notified by CNA resident went down to previous room and would not leave. This writer and DoN went to speak with resident, and tell resident her and her family had chose to move her to another room. The resident is angry with staff. The DoN encouraged the resident to calm down. The DoN was able to redirect the resident to her new room. The resident apologized for striking out at staff, but continued to be upset with room move. SS encouraged resident to speak with family about room move, and why family wanted a room move. 3/3/11 at no time - Due to resident's increased agitation, SS had the DoN notify the doctor of residents behavior. The resident also had behaviors on previous day. 3/4/11 at no time - Per other SS who spoke with staff, the resident did O.K., with new room. 3/10/11 at no time - Spoke with resident this date. Per resident, she has adjusted to her new room. A physicians order for resident #A, dated			

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	3/3/11 at 4:00 P.M., indicated the following order: Risperdal 0.5 mg's by mouth 2 times a day at 9:00 A.M., and 9:00 P.M. An interview with the Social Service Designee (SSD) #1 on 4/5/11 at 10:55 A.M., indicated on 3/3/11, Resident #A's family requested a room move for Resident #A. SSD indicated Resident #A was agitated, but she did not witness her striking anyone. An interview with SSD #2 on 4/5/11 at 3:15 P.M., indicated she witnessed Resident #A agree with her room move, then when staff were actually moving her, Resident #A began hollering. Resident #A was confused and said she could not believe staff would move someone without telling them. Resident #A wanted to call her daughter and tell her she was being moved, when in fact, her daughter had been in earlier that day and was aware of the room move. Resident #A voiced she could not remember her daughter being there. An interview with the DoN on 4/5/11 at 1:50 P.M., indicated on 3/2/11, Resident #A was agitated about being catheterized, and on 3/3/11, Resident #A was agitated about her room move. On 3/3/11, the SSD had asked her to go to Resident #A's			

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	previous bedroom. The DoN indicated Resident #A refused to leave her previously assigned bedroom. The SSD asked the DoN to notify the physician. The DoN called the physician, explained Resident #A's behaviors, and the physician ordered routine Risperdal 0.5 mg's by mouth 2 times a day. No documentation related to the Risperdal was documented in Resident #A's record. The DoN indicated staff did not document on new medications, but would notify the physician if any adverse reactions were observed. The DoN indicated Resident #A had no previous history of behaviors or psychosis prior to 3/2/11. The DoN indicated a psychological consult was never ordered for Resident #A. The DoN indicated Resident #A acted in a threatening manor, striking out at staff, but she did not observe Resident #A hit anyone. An interview with the DoN on 4/5/11 at 6:20 P.M., indicated the interdisciplinary team did not meet, and discuss possible interventions for Resident #A if she continued to display threatening behaviors, prior to administering routine Risperdal. The DoN indicated the last physician's visit for Resident #A was 2/22/11, and the physician did not assess Resident #A prior to starting her on routine Risperdal. The DoN indicated a			

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	Behavior Program was never initiated for Resident #A, because Resident #A had no further behavior episodes. An interview with Resident #A's family member on 4/4/11 at 10:04 A.M., indicated Resident #A had become increasingly lethargic after starting the routine Risperdal. Resident #A's family member indicated she had questioned a facility nurse and was informed the lethargy was likely due to Resident #A's pain medication. Nurses notes for Resident #A indicated the following: 3/22/11 at 3:00 P.M. - The resident complained of increased leg pain. The resident stated she has had trouble sleeping at night related to the pain. The resident has been very drowsy through the day, et. often falls asleep in her wheelchair. No further complaints at this time. MD notified. 3/23/11 at 10:00 A.M. - This nurse assessed the resident. Blood sugar 36, and resident unresponsive. Provided the resident with orange juice and graham crackers with peanut butter. MD notified. 3/23/11 at 10:10 A.M. New order per physician. Family, and pharmacy aware. 3/23/11 at 10:12 A.M. - The resident received Glucagon subcutaneous. Family, and pharmacy. 3/23/11 at 10:25 A.M. - Blood sugar assessment started every 15			

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	minutes. Blood sugar did rise. The resident is lethargic, aroused with difficulty. MD aware. 3/23/11 at 10:35 A.M. - New order per MD. Pharmacy, and family aware. 3/23/11 at 10:45 A.M. - Resident transported to the emergency room via cart. Family, and pharmacy aware. A local hospital note for Resident #A, dated 3/23/11, indicated the following: History of present illness - After talking to the nurse taking care of her at the facility, the resident was in her usual state of health, although for the last week has been "sedated", and this morning blood sugar was 211. Per her routine orders she received 16 units of Novolog before meal and an additional 7 units per sliding scale. When she was checked at approximately 10:00 A.M., blood sugar was 37, and the resident was unresponsive. She woke up somewhat and they gave her some orange juice and the next blood sugar was 97, and then subsequently dropped to 84. She was given 1 mg of Glucagon and transported to the emergency room since she would not respond too well to even vigorous sternal rub. Assessment and Plan - Change in mental status, most likely a combination of hypoglycemia, fluctuating blood sugars, and the most recent addition of Risperdal. I have stopped the Risperdal and will observe the			

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	resident in the hospital. A local discharge hospital note for Resident #A, dated 3/26/11, indicated the following: Hospital course - The resident was admitted for hypoglycemia, with a blood sugar of 37 evidently at the extended care facility. She did have Glycogen, and sugar did improve somewhat. When she remained somnolent, her Risperdal was stopped, and she did return to her normal level of consciousness following this. The facility's Behavior Management Psychotropic Medication Protocol Policy provided by the Resident Care Coordinator on 4/5/11 at 6:10 P.M., indicated the following: Policy: Residents with behaviors that are displayed routinely, that effect the resident's psychosocial well-being or that of other residents, or behaviors that can have potential for harm to self or others will be assessed with the development of a behavior program. Interventions developed in this program will only include the use of medications when the appropriate assessment by the physician and interdisciplinary team members has validated that non-chemical interventions alone are not successful, that these behaviors were persistent, and were not caused by preventable reasons....			

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	This federal tag relates to Complaint IN00088486. 3.1-48(a) 3.1-48(a)(4)			